

## Journal of Law and Policy

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Volume 15

Issue 3

SCIENCE FOR JUDGES VIII:

Regulating Pharmaceuticals and Scientific Issues

Regarding Asbestos

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Article 24

2008

# Federal Asbestos Legislation: Wrestling with the Medical Issues

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### Recommended Citation

Patrick M. Hanlon, *Federal Asbestos Legislation: Wrestling with the Medical Issues*, 15 J. L. & Pol'y (2007).

Available at: <https://brooklynworks.brooklaw.edu/jlp/vol15/iss3/24>

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## FEDERAL ASBESTOS LEGISLATION: WRESTLING WITH THE MEDICAL ISSUES

*Patrick M. Hanlon* \*

### INTRODUCTION

Asbestos litigation began in earnest in the 1970s, and the first proposals to substitute a federal compensation scheme for the tort “system” came almost at the same time.<sup>1</sup> These proposals and the many that followed in the succeeding decades, came to nothing. The failure of legislative reform was not due to the grand success of the tort system. On the contrary, as early as 1991, the U.S. Judicial Conference’s Ad Hoc Committee on Asbestos Litigation found that the situation with respect to asbestos litigation “has reached critical dimensions and is getting

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<sup>1</sup> The first hearings on asbestos litigation occurred in the 1970s, and from the late 1970s through 1985 asbestos legislation was a perennial item on the Congressional calendar. Congress then fell silent on the issue. The U.S. Judicial Conference’s Ad Hoc Committee on Asbestos Litigation strongly recommended legislation in 1991, but that recommendation lead only to hearings—no bill was introduced. Serious efforts at asbestos legislation did not begin until after the Supreme Court’s decision in *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591 (1997). See Patrick M. Hanlon & Anne M. Smetak, *Asbestos Changes*, 62 NYU ANN. SURV. AM. LAW 525, 557-564 (2007) [hereinafter “*Asbestos Changes*”].

worse.”<sup>2</sup> According to the Ad Hoc Committee:

Dockets in both federal and state courts continue to grow; long delays are routine; trials are too long; the same issues are litigated over and over; transaction costs exceed the victims’ recovery by nearly two to one; exhaustion of assets threatens and distorts the process; and future claimants may lose altogether.<sup>3</sup>

The Ad Hoc Committee’s call for legislation fell on deaf ears.

The future foretold by the Ad Hoc Committee came to pass. Shortly after the Supreme Court’s decision in *Amchem, Inc. v. Windsor*, 521 U.S. 591 (1997), put an end to hopes of creating an administrative claims mechanism through a broad class action settlement, asbestos litigation exploded.<sup>4</sup> New claims were being filed at a rate approaching 100,000 *per year*.<sup>5</sup> Many of these claims were concentrated in courts new to the litigation, such as Holmes County, Mississippi, which saw unprecedented verdicts for people who had physical indications of asbestos exposure but

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<sup>2</sup> REPORT OF THE JUDICIAL CONFERENCE AD HOC COMMITTEE ON ASBESTOS LITIGATION 2 (1991).

<sup>3</sup> *Id.* at 3.

<sup>4</sup> The Supreme Court in *Amchem* noted almost plaintively that, while the “argument is sensibly made that a nationwide administrative claims processing regime would provide the most secure, fair, and efficient means of compensating victims of asbestos exposure,” Congress “has not adopted such a solution.” *Amchem, Inc. v. Windsor*, 421 U.S. 591, 628-29 (1997). This was the first of several occasions in which the Supreme Court rejected the invitation to create special asbestos law to control the burgeoning mass of asbestos cases and called upon Congress to adopt a comprehensive reform. See *Ortiz v. Fibreboard Corp.*, 527 U.S. 815, 821 (1999) (“Like *Amchem* . . . this case is a class action prompted by the elephantine mass of asbestos cases, and our discussion in *Amchem* will suffice to show how this litigation defies customary judicial administration and calls for national legislation.”) (internal citations omitted); *Norfolk & Western Ry. Co. v. Ayers*, 548 U.S. 135, 166 (2003). For a comprehensive account of the aftermath of the *Amchem* decision, see *Asbestos Changes*, *supra* note 1, at 548-56.

<sup>5</sup> STEVEN J. CARROLL ET AL., ASBESTOS LITIGATION 71, Tbl. 4.1 (RAND Institute for Civil Justice 2005) [hereinafter “RAND REPORT”].

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no current breathing impairment—the so-called “unimpaired.”<sup>6</sup> Increasingly, asbestos claims were solicited all over the country and then channeled to plaintiff-friendly jurisdictions through sophisticated networks of plaintiffs’ lawyers.<sup>7</sup> The sudden escalation in asbestos litigation led to a wave of bankruptcies beginning in 2000.<sup>8</sup> By the end of 2002, the vast majority of major asbestos defendants had filed for protection under the bankruptcy laws.<sup>9</sup> The total number of asbestos bankruptcies exceeded 70, and more than two-thirds of these were filed after January 1, 2000.<sup>10</sup> The absence of traditional defendants accelerated pressures to bring new ones into the litigation, and the RAND Corporation estimated that by the end of 2002 the litigation had involved 8,400 companies throughout the American economy.<sup>11</sup>

This deteriorating situation transformed Congressional attitudes toward asbestos litigation. By early 2003, there was a bipartisan consensus that the asbestos litigation system was

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<sup>6</sup> In one such case, a Mississippi jury awarded \$150 million in compensatory (not punitive damages) to 6 men who plainly had no current impairment. See R. Parloff, *\$200 Billion Miscarriage of Justice*, FORTUNE 166 (May 4, 2002).

<sup>7</sup> *Asbestos Changes*, *supra* note 1, at 552-53.

<sup>8</sup> *Id.* at 555-56.

<sup>9</sup> The magnitude of the early 21st century asbestos bankruptcies can be illustrated by looking at the list of defendants in the seminal 1970s case against the asbestos industry, *Borel v. Paper Prods. Fibreboard Corp.*, 493 F.2d 1076 (5th Cir. 1973). Almost all of those defendants had gone bankrupt by 2002. (Fibreboard Paper Products Co & Owens Corning Fiberglass Corp. (2001), Johns Manville (1982), Pittsburgh Corning (2000), Philip Carey Corp. (part of Celotex bankruptcy, 1990), Armstrong Cork Corp. (Armstrong World Industries 2001, ACandS 2002), Ruberoid Div. of GAF (G-I Holdings, 2002), Standard Mfg and Insulating Co. (1986), Unarco Industries Inc. (1982); Eagle-Picher Industries Inc. (1991); Combustion Engineering (2003)). While many companies that eventually became important defendants were not parties to *Borel*, the mortality rate of those that were parties indicates the economic impact of asbestos litigation on the affected companies.

<sup>10</sup> RAND REPORT, *supra* note 5, at 69, 152-53. (Table D.1, collecting asbestos bankruptcies through 2004)

<sup>11</sup> *Id.* at 79.

broken and needed fixing. There was, as yet, no consensus on what to do.

The primary forum was the Senate. Because Senate rules allow a minority with 41 votes to prevent consideration of legislation, that body was considered the more difficult hurdle.<sup>12</sup> The House had little interest in taking up the asbestos issue if any legislation approved by the House would be blocked in the Senate. The Senate considered two approaches. The “medical criteria approach” would have made a limited number of changes to address the most significant abuses of the tort system.<sup>13</sup> The heart of this concept was the adoption of medical criteria that would have prevented the “unimpaired” from pursuing claims and would have tolled the statute of limitations to ensure that asbestos victims could still sue when they became sick.<sup>14</sup> Medical criteria legislation was advocated by many defendants and insurers, a portion of the asbestos plaintiffs’ bar that specialized in representing cancer claimants, and the American Bar Association.<sup>15</sup> It was opposed by the AFL-CIO,

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<sup>12</sup> Standing Rule XXII(2) provides for the closing of debate on matters other than amendment of Senate rules if “three fifths of the Senators duly chosen and sworn” vote for a so-called “cloture motion.” Normally three-fifths of the Senators duly chosen and sworn are 60—which means that 41 votes are enough to block cloture. Historically, the failure to shut off debate meant that senators would stay up all night reading the phone book in a classic filibuster. Today’s Senate is less colorful and more efficient. When it becomes clear that a matter cannot proceed, the majority leader will generally withdraw it rather than waste scarce legislative time in useless debate. During the 107th, 108th, and 109th Congresses (2001-2006) the Senate was always closely balanced between Republicans and Democrats and was for a brief period controlled by Democrats. Asbestos reform was perceived as primarily a Republican initiative. The Senate could not adopt an asbestos bill of any kind unless it appealed to enough Democrats (and commanded the support of enough Republicans) to overcome a filibuster.

<sup>13</sup> S. 413 (108th Cong. 2003), introduced by then Sen. Don Nickles (R-AZ), was the main vehicle in the Senate incorporating the “medical criteria” approach.

<sup>14</sup> *Id.* at §§ 4.6.

<sup>15</sup> A legislative proposal involving the “medical criteria” approach was negotiated in 2001 among representatives of the American Insurance Association, the “Asbestos Alliance” led by the National Association of

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most asbestos (and other) trial lawyers, and some large defendants and insurers who advocated a more radical change.<sup>16</sup>

The second approach involved developing a federal administrative compensation scheme that would for practical purposes substitute for the tort system. That approach—clearly what the Supreme Court had in mind in calling for national legislation—was proposed by the “Asbestos Study Group” or “ASG” and had the support of insurers with large asbestos liabilities.<sup>17</sup> Since the trust fund idea was in principle congenial to the AFL-CIO, it had the potential to attract support from some Democrats. However, another key Democratic

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Manufacturers, and plaintiffs’ lawyers representing cancer victims, led by Steven Kazan of Oakland. Kazan presented the case for this approach before the Senate Judiciary Committee in September 2002. Asbestos Litigation: Hearing Before the S. Comm. on the Judiciary, 107th Cong. 188-89 (2002) (Statement of Steven Kazan). The ABA’s House of Delegates adopted a resolution supporting federal legislation establishing medical criteria at its mid-year meeting in February 2003. Resolution Adopted by the House of Delegates of the American Bar Association (Feb. 2003) (on file with author). See also Asbestos Litigation Crisis: Hearing before the Senate Comm. On the Judiciary 21, 108th Cong. 61 (2003) (testimony & written submission of Dennis Archer, President-Elect of the American Bar Ass’n);.

<sup>16</sup> See *Asbestos Changes*, *supra* note 1, at 562-64; Patrick M. Hanlon & Anne M. Smetak, *Asbestos Reform in the States*, Materials Presented in ALI-ABA Conference on Asbestos Litigation in the 21st Century 1-18 (Nov. 30-Dec. 1, 2006) (discussing the “reform analysis” underlying medical criteria and other proposed tort system changes as implemented in the states).

<sup>17</sup> The “Asbestos Study Group” or “ASG” led the business interests seeking an administrative compensation system. The ASG included such companies as General Electric, Pfizer, Dow, Honeywell, Halliburton (prior to 2004), General Motors, and Ford. Several insurance companies who were major players in asbestos litigation also supported proposals for an administrative system, although as the panic of 2002 abated, some early supporters of the trust fund concept dropped away and (in the case of Liberty Mutual) even came to lead the opposition. See, for example, S 3274: The Fairness in Asbestos Injury Resolution Act of 2006, Hearing before the Senate Committee on the Judiciary, June 7 2006 (Statement of Edmund F. Kelly, Chairman and CEO of Liberty Mutual Group) available at <http://judiciary.senate.gov/hearing.cfm?id=1931> (last checked May 31, 2007); 152 Cong. Rec. S753 (daily ed. Feb. 6, 2006) (Liberty Mutual member of coalition paying about \$3 million to defeat the FAIR Act)..

constituency, the trial lawyers were united in their opposition to an administrative compensation program.

In March 2003, Senator Orrin Hatch, then chairman of the Senate Judiciary Committee, chose to press for an administrative compensation scheme which was eventually dubbed the "FAIR Act."<sup>18</sup> The Hatch bill was approved by the Senate Judiciary Committee in July 2003 with amendments that were nearly fatal.<sup>19</sup> The bill was nursed back to life through an extraordinary mediation effort by Judge Edward R. Becker of the United States Court of Appeals for the Third Circuit.<sup>20</sup> Judge Becker volunteered his time at the request of Senator Arlen Specter (R-PA), who subsequently became Chair of the Judiciary Committee in 2005. Between 2003 and 2006, Judge Becker presided over more than 50 meetings among stakeholders, brokering compromises on many issues, and recommending fair solutions of many others to Senator Specter.<sup>21</sup> The bill that

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<sup>18</sup> FAIR stands for "Fairness in Asbestos Injury Resolution." There have been several versions of the FAIR Act: S. 1125 (2003), S. 2290 (2004), S. 852 (2005) and S. 3274 (2006). S. 852 was the version eventually brought to the Senate floor in February 2006, and S. 3274 was introduced 3 months later with changes designed to address some of the objections to S. 852. Fairness in Asbestos Injury Resolution Act of 2006, S. 3274, 109th Cong., 2006. For convenience, this paper generally refers to S. 3274 unless otherwise indicated.

<sup>19</sup> See Sen. Rep. 108-18 (July 21, 2003). The most important issues are discussed in Patrick M. Hanlon, Commentary: The FAIR Act: A Freeze Frame, *Mealey's Asbestos Bankruptcy Report* v. 3, no. 1, 37, 46-48 (August 2003).

<sup>20</sup> 152 Cong. Rec. S5398 (daily ed. May 30, 2006) (resolution recognizing accomplishments of Judge Edward R. Becker).

<sup>21</sup> *Id.* In August 2003 the author attended the first meeting over which Judge Becker presided. That meeting was followed by scores of meetings and conference calls. It was an extraordinary experience. At one moment the group would be buried in detail, and then it would be debating broad questions of policy, with Judge Becker all the while encouraging, cajoling, brokering, listening, arbitrating, leading. If the stakeholders did not succeed in reaching consensus, the failure was not Judge Becker's. The disagreements were too deep, and the stakes too large. During all this time Judge Becker was fighting his own losing battle with cancer. He died in May 2006, to the deep sorrow of those who knew him.

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ultimately went to the floor in 2006 was a bipartisan bill, sponsored both by Chairman Specter and Ranking Member Patrick Leahy (D-VT), and much different from the bill introduced by Senator Hatch in 2003.<sup>22</sup>

The FAIR Act reached the floor of the Senate on February 6, 2006.<sup>23</sup> On February 14 (St. Valentine's Day), it was defeated by one vote on a motion to waive a point of order that required 60 votes.<sup>24</sup> Senator Daniel Inouye (D-HI) was absent for personal reasons and would have voted in favor of the bill had he been present.<sup>25</sup> The bill had bipartisan support: 15 Democrats joined 44 Republicans in voting to waive the point of order.<sup>26</sup> Those numbers show, however, that the bill had strong bipartisan opposition as well. The key to the bill's defeat was strong opposition by a group of at least 11 conservative Republican senators who might normally have been expected to vote for tort reform legislation.<sup>27</sup> While these senators had a number of concerns, the most important was a fear that the administrative compensation program would eventually cost far

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<sup>22</sup> Compare S. 852 (109th Cong.) with S. 1125 (107th Cong.).

<sup>23</sup> 152 CONG. REC. daily ed. S697 (February 6, 2006) .

<sup>24</sup> *Id.* at S1168-69.

<sup>25</sup> The margin of defeat may have been somewhat larger than one vote. Several Republican Senators who voted to waive the point of order are rumored to have done so because they were unwilling to challenge the Senate leadership and thought that the bill would fail anyway. Some of those senators might have changed their votes if the outcome had been riding on them.

<sup>26</sup> *Id.* at S. 1168. This count includes in the Democratic column of supporters Senator Jeffords, an Independent who caucused with the Democrats. After the decisive vote the Majority Leader, Senator Bill Frist (R-TN) changed his vote on waiving the point of order from "yea" to "nay" for reasons of parliamentary procedure. (This allowed him to move to reconsider the vote later). The vote tally in the text includes Senator Frist as among the bill's supporters; in fact he was one of the bill's principal champions.

<sup>27</sup> *Id.* The Republicans who voted to uphold the point of order killing the bill were Senators Bunning (KY), Crapo (ID), Demint (S.C.), Ensign (NV), Graham (SC), Gregg (NH), Inhofe (OK), McCain (AZ), McConnell (KY), Sununu (NH), and Thune (SD). As noted above, Senator Frist voted against waving the point of order only after the motion had already failed.



more than its advocates expected (or, some thought, admitted) and would become a federal financial responsibility.<sup>28</sup> The nightmare of these senators was the possibility that the FAIR Act would evolve in the same manner as the federal Black Lung program.<sup>29</sup> As we shall see, the “Black Lung Issue” ultimately killed the bill because it was impossible to arrive at an agreement on scientific issues regarding the appropriateness and effect of the bill’s eligibility criteria.

This Article examines the attempts of the bill’s sponsors and critics to address (or, in some cases, get around) these scientific issues. Those attempts were exceedingly difficult for two reasons. First, there were strong disagreements within the scientific community on medical issues, and each side of the political debate distrusted judgments of experts associated with the other side—in part because of the entanglement of so many experts in the litigation. Second, it was hard to assess the effect of any particular eligibility criteria in a brand new administrative context. For example, eligibility standards that worked well

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<sup>28</sup> These concerns were most clearly expressed by Douglas Holtz-Eakin, former director of the Congressional Budget Office, in a hearing on S. 3274, which was introduced in May 2006 in an effort to overcome the problems that had blocked S. 852 in S. 3274: The Fairness in Asbestos Injury Compensation Act of 2006 (S. 3275), Hearing before the S. Comm. on the Judiciary (June 7, 2006) (Statement of Douglas Holtz-Eakin), *available at* <http://judiciary.senate.gov/hearing.cfm?id=1931>.

<sup>29</sup> The leading study on the Black Lung Act is PETER S. BARTH, *THE TRAGEDY OF BLACK LUNG: FEDERAL COMPENSATION FOR OCCUPATIONAL DISEASE* (1987). Barth points out that congressional supporters of the Black Lung program consistently underestimated the costs of the program, *id.* at 283, and the coal excise taxes that were designed to shift program costs to the industry never were sufficient to offset the costs of legacy (pre-enactment) claims. *Id.* at 48-49, 190-92; *see also* Edward Rappaport, *The Black Lung Benefits Program*, CRS Report for Congress 4-6 (June 12, 2002). While the program has generally performed much more soundly since reforms in the early 1980s, the Federal Treasury has continued to be burdened with substantial costs. *See, e.g.*, U.S. General Accounting Office, *Black Lung Program: Further Improvements Can Be Made in Claims Adjudication* 7-8, GAO/HRD 90-75 (1990). As a result of its early runaway costs, Black Lung has come to symbolize the fiscal dangers that may be created by federal injury compensation programs. BARTH, *supra*, at 284.

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enough in the context of tort settlements would not necessarily work the same way in a no-fault administrative compensation program with radically lower transaction costs.<sup>30</sup>

In Part I, I will show why developing politically acceptable medical and exposure criteria despite profound distrust of the medical experts was a central challenge for the framers of asbestos compensation legislation. After explaining the basic structure of the FAIR Act in Part II, I will turn in part III to an analysis of the various strategies used to resolve, or avoid having to resolve, the important medical questions and the difficulties that each of those strategies entailed. As we shall see, despite considerable political creativity, at the end of the day the effort to resolve or evade the medical issues generated problems that eroded confidence in the bill and contributed to its demise.

#### I. WHY IS THIS SO HARD?

The FAIR Act was an effort to substitute a compensation system based on cause for one based on fault.<sup>31</sup> Compensation would be based not on the responsibility of any particular defendant but on whether the claimant had an asbestos-related disease. Conceptually, if not in the details of its operation, the FAIR Act resembled workers' compensation, where the question of fault is replaced by work-relatedness. The problem, however, was that the amount of compensation provided by the FAIR Act was much higher than is usual in cause-based programs. Politically, therefore, the FAIR Act would only be acceptable to defendants and insurers (and their supporters in the Congress) if the overall cost were controlled by (1) reductions in transaction costs (especially the fees of plaintiff and defense attorneys), (2)

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<sup>30</sup> These and other problems encountered by the FAIR Act in its tortured history are discussed in greater detail in Patrick M. Hanlon, *Elegy for the FAIR Act*, 12 CONN. INS. L. J. 518 (2006) [hereinafter "*Elegy*"].

<sup>31</sup> For this distinction see Kenneth S. Abraham & Lance Liebman, *Private Insurance, Social Insurance, and Tort Reform: Toward a New Vision of Compensation for Illness and Injury*, 93 COLUM. L. REV. 75, 78-79 (1993).

elimination of substantial compensation for tens of thousands of people who had some physical manifestation of asbestos exposure but were otherwise quite well, and (3) eligibility criteria that would preclude unexpectedly high claiming rates.

In a perfect world, the adequacy of the bill's eligibility criteria would be a question of medicine. One would look to independent and impartial doctors to draw the necessary lines (as was done in the case of cancers other than mesothelioma and lung cancer). In this imperfect world, however, that was easier said than done. Over a 25-year period, in which \$70 billion had already changed hands, it was very difficult to find doctors generally regarded as "independent" and "impartial." Most prominent experts in asbestos medicine had long since taken sides, and many depended on the litigation for a substantial part of their income. Moreover, the FAIR Act could only work if the eligibility criteria were kept simple and objective, and it is the almost universal tendency of doctors (not to mention lawyers) to want to make informed judgments based upon a consideration of all the relevant factors. A judgment-based system, however, would not only have high transaction costs, but would make everything depend on which physicians were making the judgments (which all too often was thought of as a question of which side's physicians were making the judgments).

Thus, the fate of the FAIR Act necessarily depended on how well it could solve the problem of developing politically acceptable medical criteria despite profound distrust of the (other side's) medical experts. As discussed below, the Senate used every means at its disposal to do this. In some instances it was able to defer medical questions to the National Academy of Science's Institute of Medicine (IOM), one of the few organizations that enjoyed a general (though not universal) level of trust on all sides. In some instances it was able to rely on general compromises made in the tort system through what I will call a "settlement" model. And in some cases, it simply punted medical issues to Physicians Panels for case-by-case resolution (notwithstanding the inefficiencies that would have introduced into the administrative process). Much of what was done was ingenious, but, at the end of the day, it was not

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enough.

## II. THE FAIR ACT'S BASIC STRUCTURE

The FAIR Act, had it been enacted, would have established an administrative scheme for the compensation of asbestos-related diseases.<sup>32</sup> The program would have been administered by an administrator in the Department of Labor, and would have been paid for by assessments on asbestos defendants and insurers.<sup>33</sup>

The program was designed to be a no-fault compensation system with an emphasis on efficiency. Because the system was “no-fault,” it would no longer have been necessary for claimants to link their disease with any defendant.<sup>34</sup> It would, however, still have been necessary to show that the claimant’s disease was actually caused by asbestos.

The administrative provisions of the FAIR Act were for the most part hammered out in discussions between representatives of organized labor, defendants, and insurers. The administration would have been non-adversarial, reflecting the point of view of the AFL-CIO. In some medical categories, compensation would have been extremely fast and certain. For example, claimants for mesothelioma (a deadly cancer whose only known cause is asbestos exposure) would have been able to recover based only on a reliable diagnosis of mesothelioma and evidence of some identifiable exposure to asbestos. In other categories, however, claims would have been subject to more searching scrutiny. For example, household (or “take-home”) exposure claims for diseases other than mesothelioma would have been considered by a Physicians Panel for an individualized determination of

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<sup>32</sup> S. 3274, § 2 (b).

<sup>33</sup> S. 3274, §§ 101 (b) (appointment of Administrator), 202 (a) (defendant funding), 212 (a) (insurer funding). The bill would also have swept into the program the assets of bankruptcy trusts, which are successors to the liabilities of defendants that have been reorganized under the bankruptcy laws. *Id.* § 402 (f).

<sup>34</sup> S. 3274, § 112 (2006).

causation.<sup>35</sup> The underlying concept was to provide relatively light review in situations where the probability of error was small and more searching scrutiny in situations that were more problematic.

The FAIR Act emphasized the importance of ensuring the quality of the data used in the administrative process.<sup>36</sup> All medical tests had to meet applicable standards regarding equipment, testing methods and procedures.<sup>37</sup> Diagnoses of non-cancerous conditions had to be based on physical examinations performed by a diagnosing physician and x-rays read by a qualified B-reader, and they also had to consider exposure and smoking history.<sup>38</sup> All information provided in support of a claim was subject to audit,<sup>39</sup> and there were specific requirements for the auditing of B-readings and smoking assessments.<sup>40</sup> The Administrator also had the authority to request additional information, including new x-rays or CT scans.<sup>41</sup>

The bill provided for outreach by the Administrator to

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<sup>35</sup> *Id.* § 121 (c) (3). The typical “take-home” exposure occurs when a worker brings asbestos home on his clothes, and his spouse is exposed while doing the wash. These cases can also involve the worker’s children. See Patrick M. Hanlon and Elizabeth Runyan Geise, *Asbestos Reform—Past & Future*, MEALEY’S LITIGATION REPORTS: ASBESTOS.v. 22, no. 5, at 43-44 (April 4, 2007)

<sup>36</sup> Quality control of the data submitted in support of an application was especially important because of the history of medical fraud and abuse that has made asbestos litigation such a scandal. See generally the comments of Judge Janice Graham Jack, *In re Silica Products Liability Litigation*, 398 F. Supp. 2d 563, 596-637 (S.D. Tex. 2005), which emphasize the similarity between silica and asbestos litigation in this regard.

<sup>37</sup> S. 3274, § 121 (b) (3).

<sup>38</sup> *Id.* § 121 (b) (2) (A) The physical examination and B-reading requirements (but not the smoking-history requirement) were excused for deceased claimants. *Id.* § 121 (b) (2) (B).

<sup>39</sup> *Id.* § 115 (a) (1).

<sup>40</sup> *Id.* §§ 115 (b), (c). The auditing of B-reader reports is not just a system function but can affect individual claims.

<sup>41</sup> *Id.* § 121 (b) (3).

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inform potential claimants of the availability of the program.<sup>42</sup> Claimants did not have to be represented by attorneys, and attorneys' fees were limited to 5 percent of the claimant's recovery.<sup>43</sup> Adverse decisions by the administrator were reviewable in the Court of Appeals for the area where the claimant resided when his application was filed.<sup>44</sup>

The bill would have established nine disease "levels" with exposure and medical criteria and an award value for each one. Occupational exposure was generally required for all disease categories other than mesothelioma,<sup>45</sup> although as discussed below, people with non-occupational exposures could recover in some circumstances. The statutory disease levels are summarized in Table 1.

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<sup>42</sup> *Id.* §§ 104 (a), 225 (b). The bill also provided for a medical screening program whose primary purpose was to identify potential claimants. *See generally id.* § 225(c).

<sup>43</sup> *See* S. 3274, § 104 (e). S. 3274 would have allowed a reasonable fee in excess of 5 percent in the event of a successful administrative appeal. *Id.* § 104 (e) (1) (B). The attorney fee limitation did not apply to judicial review.

<sup>44</sup> *Id.* § 302(a).

<sup>45</sup> The occupational exposure requirement is incorporated into the medical criteria of each of the disease levels from I to VIII. *Id.* §§ 121 (d) (1)-(8). Level IX—Mesothelioma does not require exposure to be occupational. *Id.* § 121 (d) (9) (B).

<b>Table 1: Disease Levels and Award Amounts Under the S. 852</b>			
Level I – Unimpaired Non-Malignant Conditions receive reimbursement for medical monitoring but no monetary compensation			
Level II Mixed Obstructive– Restrictive Disease	\$25,000	Level VI “Other Cancer”	\$200,000
Level III Asbestos Disease with impairment	\$100,000	Level VII Lung Cancer without Asbestosis	\$300,000[s] \$725,000[x] \$800,000[n]
Level IV Asbestos Disease with More Severe Impairment	\$400,000	Level VIII Lung Cancer with Asbestosis	\$600,000[s] \$925,000[x] \$1,100,000 [n]
Level V Asbestos Disease with Most Severe Impairment	\$850,000	Level IX Mesothelioma	\$1,100,000
Note: Smoking status, indicated by [s] = smoker, [x] = former smoker, and [n] = non-smoker.			

Claimants who did not meet the exposure and medical criteria for any disease level could seek compensation on the basis of an individualized review by a Physicians Panel as an “exceptional medical claim.”<sup>46</sup> Several kinds of claim that present special difficulties of proof were also sent to the Physicians Panels. These included claims based on “take-home” exposures and claims for cancers other than mesothelioma and lung cancer.<sup>47</sup>

<sup>46</sup> *Id.* § 121 (g).

<sup>47</sup> *Id.* § 121 (c). In litigation, most of “take home” situations involve

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Although the bill referred to the various disease categories as “levels,” that only meant that award values increased from level to level. For example, a claimant with lung cancer might be in Level VII or Level VIII. The difference in compensation between those two categories does not relate to how sick the claimants are, but to the strength of their causation evidence. Similarly, a person who qualified for Level II could be much more seriously impaired than many who qualified for Level III. The difference in compensation is due to the fact that most Level II cases will be primarily due to chronic obstructive pulmonary disease (*e.g.*, emphysema or chronic bronchitis, both caused by smoking) with relatively weak evidence of an asbestos connection, while Level III cases have a clearer link to asbestos exposure.

The FAIR Act would have been financed by defendants (up to \$90 billion), insurers (up to \$46.25 billion), and asbestos trusts established as a result of chapter 11 reorganizations of previous defendants such as Johns Manville (expected to amount to \$4 billion).<sup>48</sup> The defendants’ contributions were based on a complex and exception-riddled set of formulas that took into account (1) whether they were in bankruptcy or not (the bankrupts paid more), (2) how large their previous asbestos expenditures had been, and (3) how big they were (measured by gross revenues).<sup>49</sup> The insurers’ contribution would have been determined after enactment by an Asbestos Insurance Commission.<sup>50</sup> The bill would have channeled essentially all of

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mesothelioma claims. The bill did not require those claims to be referred to a Physician’s Panel, but did it require an individualized determination of causation when other diseases are involved. For “other cancer” claims, see *infra* notes 65-73.

<sup>48</sup> S. 3274, §§ 202 (a) (1) (defendants), 212 (c) (2) (insurers), 402 (f) (trusts). Section 402(f) requires transfer of substantially all trust assets (which would have exceeded \$4 billion), but payments made into trusts established after a certain date would have been subject to credits against the defendants’ and insurers’ obligations. *Id.* § 420 (f) As a result, the estimated proceeds from the trusts were fixed at \$4 billion.

<sup>49</sup> *Id.* §§ 202-205.

<sup>50</sup> *Id.* § 212.



the trusts' assets for the payment of future bodily injury claims into the national fund.<sup>51</sup>

Since the funding for the FAIR Act was capped at about \$140 billion, it was extremely important to be sure that this amount was enough. Compared to the expected cost of the tort system, funding seemed ample. Respected estimates of future costs of the tort system as of 2002 were in a range of \$130 to \$195 billion—and that was a system in which almost 60 percent of the total cost went to lawyers and experts for both sides.<sup>52</sup> The FAIR Act's non-adversarial structure should have greatly reduced transaction costs (essentially eliminating the defense side in favor of a more efficient administrative structure and significantly restricting claimants' costs). Moreover, between 2002, when the cost estimates were made, and 2006, when the FAIR Act came to a vote, several billion dollars had been spent in settling claims or paying judgments, presumably reducing the amount of future claims that would be addressed by the bill. All of this presumed, however, that claiming in the administrative system would resemble claiming in the tort system. That in turn depended on how the bill's eligibility criteria would work in practice.

If the expectations of the bill's sponsors were disappointed, and the Fund ran out of money, the bill required the program to sunset.<sup>53</sup> However, many senators, especially conservative opponents, believed that future Congresses would not allow the program to end once it became established.<sup>54</sup> The general lack

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<sup>51</sup> *Id.* § 402 (f).

<sup>52</sup> As of 2002, past costs were approximately \$70 billion and estimates of total costs ranged from \$200 billion (Tillinghast) to \$265 billion (Millman). Thus, estimated future costs ranged from \$130 to \$195 billion. These were, of course, in nominal dollars, not present value. RAND Report, *supra* note 5, at 92, 105. The RAND Report estimated that historically only 42 percent of the money spent on asbestos litigation reached plaintiffs—the rest was spent on transaction costs, primarily defense costs and plaintiffs' attorneys' fees. *Id.* at 104.

<sup>53</sup> S. 3274, § 405 (f).

<sup>54</sup> See testimony of Douglas Holtz-Eakin, *supra* note 28. The author often encountered similar views in discussions with members and staff.

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of faith in the sunset provisions of the bill put even more pressure on certainty that the bill's eligibility criteria would work as expected.

### III. CONTESTED GROUND

#### *A. An Overview*

At the outset, it is useful to consider how eligibility requirements and award values ought to be set. There are at least two basic approaches: the medical model, where eligibility criteria are based on the best medical evidence, and the settlement model, which bases eligibility on the practices followed in the tort system except where Congress believes those practices should be overridden for policy reasons.<sup>55</sup>

The FAIR Act mainly followed the settlement model. Because asbestos was a mature mass tort, what claimants received in the tort system would be at least the point of departure for determining the fairness of award values. Moreover, fundamental disagreements on medical issues tended to discourage compromise, while the use of a settlement model based on previous compromises tended to facilitate it.

Nevertheless, several difficulties arose from the use of the settlement model to establish eligibility. First, because the model is built on compromise, the bill was always open to the accusation of paying people who should not be paid or not paying people who should be (based on partisan views of the medical evidence).<sup>56</sup>

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<sup>55</sup> *Elegy*, *supra* note 30, at 550-51.

<sup>56</sup> For an excellent expression of this disquiet, see S. REP. NO. 108-18, at 98-103 (2003) (Additional Views of Senator Jon Kyl). Senator Kyl's summary of the medical issues was based upon statements from very well respected doctors and scientists—all of which were associated with the defendants' point of view. *See id.* The opinions of those doctors were rejected by many other well respected doctors and scientists who were associated with the plaintiffs' point of view. *See id.* To rely on one set of doctors rather than another is more or less what a jury does when it decides for the plaintiff or the defendant. That approach doesn't lend itself to a

Second, settlement patterns in the tort system tend to reflect typical situations, while legislation must be drafted to deal with situations that may be rare in litigation but are important to members of Congress. Thus, for example, there are very few cases in the tort system that involve non-occupational exposures (if “take-home” exposure is considered occupational), but non-occupational exposure is, as shown below, an explosive political issue.

Third, the settlement model reflects settlement practices based on a particular state of medical technology.<sup>57</sup> But the FAIR Act was designed to last for 50 years or more. Technological change will inevitably change the assumptions on which model settlement patterns were based. The controversy over CT scans, discussed below, illustrates this difficulty.

With these overarching considerations in mind, we shall turn to two difficult areas—the Act’s medical categories and proof of exposure.

### *B. The Medical Categories*

Not all of the medical categories of the FAIR Act were controversial. For example, one of the pillars of the FAIR Act was its choice to provide only medical monitoring, and not monetary compensation, for unimpaired non-malignant claims (Level I).<sup>58</sup> This policy was probably the most important override of tort system practices. Other medical categories were also mostly uncontroversial.<sup>59</sup> The controversy revolved around “mixed” obstructive-restrictive disease (Level II), “other cancers” (Level VI), and lung cancer without asbestosis (Level VII).

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legislative process based on coalition building where the stakes are large and the science unclear.

<sup>57</sup> S. 3274, § 131 (b) (1).

<sup>58</sup> *Id.*

<sup>59</sup> Uncontroversial categories include mesothelioma (Level IX), lung cancer with asbestosis (Level VIII), and most non-malignant diseases (Levels III through V). *Elegy*, *supra* note 30, at 551-52.

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*1. Level II: Mixed Obstructive-Restrictive Disease*

The theory behind Level II is that for some people asbestos-related “restrictive” diseases may contribute to impairment that is caused primarily by chronic obstructive pulmonary disease. Standard pulmonary function tests do not detect such dual-cause impairment.<sup>60</sup> In the tort system, such cases receive, if anything, much lower settlements than claims involving impairment that has a clearer relationship to asbestos-related disease.

The tort-system compromise was carried over into Level II under the FAIR Act. The award value for that category was only \$25,000.<sup>61</sup> However, while the bill’s general approach to Level II had roots in the tort system, its specific criteria were a

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<sup>60</sup> The bill relied upon two pulmonary function tests. One, “total lung capacity” or “TLC” measures the total volume of the lungs including both “vital capacity,” the volume of air a person breathes in and out, and the “residual volume,” which is the volume of air that is always in the lungs. Obstructive lung disease often increases TLC, because an increase in the residual volume due to the trapping of air in the lungs more than compensates for a reduction in vital capacity. Since the bill detected impairment by a reduction in total lung capacity, it was theoretically possible that over-inflation would offset the reduction in lung capacity due to asbestosis, thus disguising an impairment that is in part asbestos-related. See Scott Barnhart, *et al.*, *Total Lung Capacity: an Insensitive Measure of Impairment in Patients with Asbestosis and Chronic Obstructive Pulmonary Disease?*, 93-2 CHEST 299 (1988). The other major way of determining impairment was to look at “forced vital capacity” or “FVC”), basically the amount of air a person can exhale with maximum effort. FVC decreases in the case of both obstructive and restrictive disease. However, the ratio between the amount of air people can exhale in the first second (called FEV<sub>1</sub>) and the total amount they can exhale tends to decrease if obstructive disease is present. INTERMOUNTAIN THORACIC SOCIETY, CLINICAL PULMONARY FUNCTION TESTING 6 (2d ed. 1984). The FAIR Act would have weeded out obstructive disease by imposing a limit on the permissible decline of FEV<sub>1</sub>/FVC. But that decline just shows the presence of obstruction; it does not necessarily exclude the possibility that a restrictive disease such as asbestosis may make some contribution to the overall fall in forced vital capacity.

<sup>61</sup> By comparison, a claimant who qualifies for Level III (which involves less impairment but a greater probability of asbestos causation) would receive \$100,000. S. 3274, § 203 (g) (2) (C).

troubling product of legislative bargaining. The principle underlying Level II was supposed to be that mixed obstructive-restrictive disease should be inferred when the x-ray evidence of an asbestos contribution is especially strong. For that reason, the minimum ILO score to qualify for compensation was set at 1/1—one step higher than the minimum abnormal reading of 1/0.<sup>62</sup> However, it was still possible to qualify for Level II based on pleural plaques (which do not involve any scarring of lung tissue), without any asbestosis at all.<sup>63</sup> Moreover, an ILO score of 1/1 was a relaxed test for showing that an asbestos-related condition contributed something to impairment related to obstructive lung diseases. The American Bar Association's recommended medical criteria, adopted in 2003, would have required an ILO score of 2/1 or higher in a similar situation.<sup>64</sup>

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<sup>62</sup> S 3274, § 121 (d) (2). The ILO system for reading chest x-rays was initially developed for the purpose of assuring consistency in epidemiological studies of lung diseases, but it has been widely used as a diagnostic tool in administrative and judicial proceedings relating to a variety of lung conditions. People qualified on the basis of an examination to apply the ILO system—so-called “B” readers—look at the profusion, size, shape, and location of opacities on x-ray films. Profusion is the concentration of small opacities in a unit area in an x-ray film. It may indicate interstitial fibrosis—scarring in the parenchyma or tissue of the lung—while location and size and shape provide an indication of whether scarring is due to asbestos, silica, or other causes. Profusion is rated on a 12 point scale in the form of A/B. A is the B reader's final judgment on the degree of profusion, with 0 being normal and 3 being most abnormal. B indicates whether the reader considered rating profusion one more or less than the score shown by A. Thus, for example, a 1/0 reading indicates that the reader decided that profusion was a “1”—the minimum abnormal level—but seriously considered the possibility that it was a “0”—normal. A 1/0 x-ray is therefore the lowest abnormal level. A 1/1 x-ray, in contrast, is unambiguously abnormal, but still involves a relatively low level of profusion. The use of the ILO classification system is described in INTERNATIONAL LABOUR ORGANIZATION, GUIDELINES FOR THE USE OF THE ILO INTERNATIONAL CLASSIFICATION OF RADIOGRAPHS OF PNEUMOCONIOSES, REVISED EDITION 2000 at 3-6 (2002).

<sup>63</sup> See S. Rep. 109-97, at 100.

<sup>64</sup> In February 2003, the American Bar Association House of Delegates recommended the adoption of medical criteria legislation that would defer the claims of the unimpaired. See ABA Standard for Non Malignant Asbestos

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*2. Level VI “Other Cancer”*

While the evidence is clear that asbestos causes lung cancer and mesothelioma, other cancers are arguably due to asbestosis as well. Some of these cancers are very common, while others are rare.<sup>65</sup> The epidemiological evidence in favor of general causation is relatively weak for all of these cancers, but it is strong enough as a practical matter to allow “other cancer” cases to get to a jury in many jurisdictions. Thus, depending on the jurisdiction, these cases have settlement value.<sup>66</sup>

Level VI presented in acute form the problem of reconciling medical and settlement models. Since Level VI cancers had value in the tort system, the settlement model suggested that they should be compensated—if on a discounted basis—under the Act. And in fact, the bill provided as a default option that Level VI cancer claimants would receive \$200,000, a small fraction of the amount received for lung cancer or mesothelioma. The medical model, however, suggested that some or all of the “other cancers” should receive nothing at all.

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Related Disease Claims February 2003. Such legislation necessarily results in binary, “go” and “no-go” decisions: it is impossible to compromise by discounting awards. An objection to medical criteria is that it rules out the claims of people who are impaired by obstructive disease but who have a strong case that there is some asbestos contribution to their impairment. To address this situation, the ABA recommended allowing plaintiffs to pursue their cases in court if they had sufficiently strong radiographic evidence of asbestosis (an ILO reading of 2/1). *Id.* at 1-2.

<sup>65</sup> By far the most prevalent of the “other cancers” is colorectal cancer. *See* AMERICAN CANCER SOCIETY, CANCER FACTS & FIGURES 2006, 4 (2006). According to the American Cancer Society, an estimated 148,610 new cases of cancer of the colon or rectum will be diagnosed in 2006. *Id.* The estimated incidence of the other cancers in Level VI is 8,950 (pharynx), 14,550 (esophagus), 22,800 (stomach), and larynx (9,510). *Id.* These rates are for both sexes. Since substantial asbestos exposure took place primarily among males, it is also useful to look at incidence among men: colon and rectum (72,800), pharynx (6,820), esophagus (11,260), stomach (13,400), and larynx (7,700). *Id.*

<sup>66</sup> For this reason, “trust distribution procedures” of bankruptcy trusts, which tend to reflect settlement practices, compensate most or all of the Level VI cancers.

In most instances, the FAIR Act followed the settlement model and did not attempt to resolve medical issues. With regard to the “other cancers,” however, it took a different tack. There were three reasons for this. First, because “other cancer” cases were rarely pursued in the tort system, those who saw themselves as claimant advocates did not have a strong reason to resist forcing the medical issues. Second, the defense side feared that the a no-fault system might attract a large volume of claims that currently were not made in the tort system. Because some of the “other cancers”—especially colon cancer—were common, the financial consequences of a significant increase in claims for “other cancer” could threaten the viability of the entire program. Thus, defendants and insurers were willing to press for a medically based decision. Finally, each side was confident that a neutral arbiter would favor its position.

Thus, the FAIR Act would have required the Institute of Medicine of the National Academy of Sciences (“IOM”) to study the scientific literature on causation and to determine which if any of the Level VI cancers could be caused by asbestos.<sup>67</sup> If the IOM decided that a particular cancer was not caused by asbestos, that cancer could no longer be compensated under the Act.<sup>68</sup>

As it turned out, Senator Specter, the bill’s Republican co-sponsor, secured an appropriation to fund the IOM study in anticipation of enactment of the bill. Through a contract with the National Institutes of Health, the IOM established a committee to determine whether there is a causal relationship between asbestos and colorectal, laryngeal, esophageal, pharyngeal, or stomach cancers.<sup>69</sup> The committee was chaired by Dr. Jonathan

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<sup>67</sup> § 3274, § 121(e)

<sup>68</sup> *Id.*

<sup>69</sup> INST. OF MED. OF THE NAT’L ACADS. ASBESTOS: SELECTED CANCERS 6-7 (2006). The development of the IOM analysis of “other cancers” is described in Jonathan M. Samet, *Asbestos and Causation of Non-Respiratory Cancers: Evaluation by the Institute of Medicine*, 15 J.L. & POL’Y 1117 (2007) The decision to refer Level VI claims to the IOM was originally made in 2003 and was not controversial thereafter. Accordingly, neither the stakeholders nor the senators ever had an occasion to scrutinize rigorously the

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Samet of Johns Hopkins University (an eminent epidemiologist with no previous connection to asbestos litigation) and issued its report in June 2006. The committee found that there was “sufficient” evidence of asbestos causation—the standard envisioned by the sponsors of the bill—only in the case of laryngeal cancer—which represents roughly 5 percent of the cancers listed under Level VI.<sup>70</sup>

While general causation of the various “other cancers” was left to the experts at the IOM, the eligibility criteria for the cancers that were found to be caused by asbestos were set forth in the bill. These criteria were *not* based on medicine—how could they be, when they applied to several different cancers some of which might not be caused by asbestos at all? They were based on settlement practices in the tort litigation. An “other cancer” claimant could therefore recover by showing 15 weighted years of exposure plus the presence of non-malignant asbestos-related disease (which could include either asbestosis or pleural disease).<sup>71</sup> Both years of exposure and presence of a

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standards that should be applied to evaluating cancer causation in the study. For example, the level of evidence that ruled a cancer in or out was not made clear, and the committee had to do its best with an ambiguous charge. As a result, some Congressional staff raised what were basically policy questions as to whether a cancer should be included in Level VI if there was merely “suggestive” evidence of a causal relationship to asbestos. *Id.* at 1130. Similarly, no one ever asked the IOM to decide what the appropriate medical criteria would be if it found that asbestos was a general cause of a certain kind of cancer. Such questions would have raised important policy issues that could have made the basic strategy of the negotiators—deferring resolution of the medical issue to a trusted medical expert—impossible. The essence of that strategy was an attempt to transform a policy question into a technical one.

<sup>70</sup> *Id.* According to the American Cancer Society, estimated new cases of the “other cancers” included in Level VI for 2007 is 213,680, while the estimate for laryngeal cancer was 11,300. American Cancer Society, Cancer Facts and Figures 2007, at 4 (“Estimated New Cancer Cases and Deaths by Sex for All Sites 2007”).

<sup>71</sup> The FAIR Act weights exposure based on occupational setting and when the exposure took place. Thus, for example, one year of exposure working in shipyards in World War II is worth 4 years of exposure working around asbestos in an ordinary setting. Moreover, exposures after 1986 are weighted 1/10 and exposures from 1976 through 1986 are weighted 1/2



non-malignant disease were indirect indicators that the claimant had a great deal of exposure. No one argued that asbestosis or pleural disease was an independent cause of any of these cancers. In short, the logic behind the criteria was the logic of settlement, not the logic of science.

Conservative skeptics thought that the absence of a scientific basis for the Level VI criteria would allow many people whose cancer was not caused by asbestos to qualify for payment. Because some of the “other cancers”—especially colon cancer—were quite prevalent, the skeptics worried that paying “false positives” could undermine the financial viability of the program, resulting in its collapse—and pressure for a federal bailout.<sup>72</sup> This disquiet was exacerbated by the possibility that changes in diagnostic technology—particularly developments in CT scans and other imaging techniques—could make the practical compromise reflected in the other-cancer criteria unreasonable. This problem affects other medical categories as well, especially Level VII lung cancers, and is discussed in Part II (B)(4) below.<sup>73</sup>

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because increasingly stringent regulation reduced exposure levels over time. See S. 3274, 109th Cong. § 121 (a) (16) (2006).

<sup>72</sup> See American Cancer Society, *supra* note 70, at 4 (estimating the incidence of new colon and rectal cancers in 2007 as 112, 340 and 41, 420, respectively).

<sup>73</sup> A second problem with Level VI was the possibility that criteria workable in one institutional arrangement (the tort system and bankruptcy trusts) might encourage a flood of new claims in a different arrangement (a no-fault compensation scheme). See Charles E. Bates and Charles H. Mullin, Analysis of S. 852 Fairness in Asbestos Injury Resolution (FAIR) Act 2 (2005) (“The Fair Act would create entitlements for many people with lung and other cancers who were not compensated in the historical tort environment.”). This possibility, while important for Level VI, is even more important in Level VII (lung cancer claims without asbestosis). The problem here is not necessarily that *undeserving* claims would be compensated, but rather that a reduction in transaction costs in a no-fault administrative system would greatly increase the rate of claiming (whether the medical criteria are valid or not). This issue lies at the heart of concerns about the financial viability of the program.

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*3. Level VII—Lung Cancer without Asbestosis*

It is generally agreed that lung cancer in a person who has both extensive exposure to asbestos and asbestosis may be attributed to the asbestos exposure. The FAIR Act addressed this easy case in Level VIII—Lung Cancer With Asbestosis. The controversy arises when the individual does not have asbestosis. Experts argue over whether lung cancer can be attributed to asbestos exposure only if asbestosis is diagnosed or whether such an attribution can be made even in the absence of asbestosis if exposure levels are high enough.<sup>74</sup> The FAIR Act compromised. Level VII—lung cancer without asbestosis—followed the more liberal view that the presence of asbestosis was not an absolute prerequisite for a finding of causation—as long as there was sufficient exposure. The bill adopted a heightened exposure requirement (12 weighted years) and also required pleural changes (which are a confirmation of exposure). Then, in recognition of the fact that Level VII allows an award with weaker evidence of causation, the bill reduced the award value in Level VII (as compared to Level VIII).<sup>75</sup> This

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<sup>74</sup> For the view that asbestosis is a prerequisite for attributing lung cancer to asbestos exposure, see R. Jones, *Asbestos Exposure and Thoracic Neoplasms*, SEMINARS IN ROENTGENOLOGY, v. XXVII, No. 2 94 (April 1992); W. Weiss, *Asbestosis: A Marker for the Increased risk of Lung Cancer Among Workers Exposed to Asbestos*, 115 CHEST 536 (1998); Letter of James R. Crapo to Sen. Jon Kyl (July 22, 2003), appendix E to Additional Views of Sen. Jon Kyl, SEN. REP. 108-118, at 64-65 (2003). For the contrary view see D. Egilman & A. Reinert, *Lung Cancer and Asbestos Exposure: Asbestosis is Not Necessary*, 20 AM. J. INDUS. MED. 398 (1996); Consensus Report, *Asbestos, Asbestosis, and Cancer: The Helsinki Criteria for Diagnosis and Attribution*, SCAND. J. WORK. ENVIRON. HEALTH 1997; 23: 311, 314 (“Heavy exposure, in the absence of radiologically diagnosed asbestosis, is sufficient to increase the risk of lung cancer.”).

<sup>75</sup> For smokers, the value of a Level VII lung cancer claim is \$300,000, as opposed to \$600,000 for a Level VIII claim. Previous versions of the FAIR Act allowed lung cancer claimants to establish causation on the basis of asbestos exposure alone, even in the absence of pleural changes confirming actual exposure. S. 2290, 108th Cong. § 121 (d) (7) (2004); S. 1125, 108th Cong. § 121 (d) (7) (2003) (reported). In a major concession to the Republicans on the Judiciary Committee, however, Senators Specter and

maneuver—reducing the claim value in return for less restrictive eligibility criteria—is a hallmark of the settlement model. In situations where causation is unclear, the medical model suggests a very different approach: strengthening the eligibility criteria and then paying those who pass the tighter criteria the same amount of money as others with the same disease. The medical model can only work, however, if Congress resolves the scientific dispute over whether in fact lung cancer can be attributed to asbestos if the claimant does not have asbestosis. Congress does not have the expertise to resolve scientific questions in that way, and so its instinct is to turn medical questions into political questions, by way of compromise.<sup>76</sup>

The FAIR Act's treatment of lung cancers without asbestosis was by far the most controversial eligibility issue. Getting the lung cancer criteria wrong could have tremendous consequences. The American Cancer Society estimates that 213,380 lung cancers (114,760 in men) will be diagnosed in 2007.<sup>77</sup> If too stringent, the lung cancer criteria could deprive many dying people of compensation; if not stringent enough, the flood of claims could doom the system.

Although the lung cancer question could not be resolved on the basis of the medical model, the settlement model had its own problems. In part the problem was due to the fact that exposure reconstruction is expensive, time consuming, and uncertain.

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Leahy agreed in spring of 2005 to delete the relevant medical category (the "old" Level VII) from the current version of the bill. This concession provoked the ire of some Senate Democrats, led by Senator Edward M. Kennedy, who sought to restore the old Level VII category or at least allow claimants who would have qualified under Level VII to bring asbestos claims in the tort system. 152 Cong. Rec. S1265 (daily ed. Feb. 14, 2006) (amendment proposed by Sen. Kennedy).

<sup>76</sup> Conservatives would have preferred to eliminate Level VII altogether, thus in effect siding with those who believed that lung cancer cannot be attributed to asbestos in the absence of asbestosis. However, too many responsible experts disagreed with that conclusion to make that outcome possible. *But see* Bailey v. Mobil Oil Corp., 187 S.W.3d 265 (Tex. App. 2006) (excluding expert testimony that a smoker's lung cancer was due to asbestos without a concomitant finding of asbestosis).

<sup>77</sup> *See* American Cancer Society, *supra* note 70, at 4.

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Thus, eligibility cannot practically be premised on direct estimates of exposure. In level VII, the drafters of the bill relied on two indirect indicators of exposure—the number of years spent in occupations characterized by exposure to asbestos during particular periods and the presence of pleural changes. These indicators were only roughly related to the threshold of exposure that many experts thought was necessary for an attribution of lung cancer to asbestos. Moreover, the prevalence of pleural changes, in particular, depended on diagnostic techniques, and a move from standard x-rays to CT scans had the potential of greatly increasing the number of lung cancer sufferer who could meet the bill's criteria for compensation. Since lung cancer values were thought to be high compared to tort system values, there was a substantial concern that the Level VII category might bankrupt the program.<sup>78</sup>

Interestingly, in 2005, the English also confronted the problem of deciding whether and when lung cancers without asbestos should be compensated as asbestos-related. The English Industrial Injuries Benefits Scheme pays benefits to workers with prescribed asbestos-related diseases.<sup>79</sup> In 2005, the Industrial Injuries Advisory Council recommended a number of changes in the program's prescription for lung cancer (essentially, the

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<sup>78</sup> See C. Bates & C. Mullin, *supra* note 73. As is true of other scientific issues, the number of people who would qualify for compensation under Level VII was disputed. See *Recent Developments in Assessing Future Asbestos Claims Under the FAIR Act: Hearing before the Senate Committee on the Judiciary*, 109th Cong. (2005) (statements of witnesses Douglas Holtz-Eakin, Laura Welch, & Denise Martin), available at <http://judiciary.senate.gov/hearing.cfm?id=1682>. At the end of the day, however, science could not resolve this argument. Opponents of the bill wanted a level of certainty that no one could provide, because the consequences of being wrong were so great and because they didn't believe that the safety valve provided by the bill's sunset provisions would actually work. Supporters, who assumed the bill would be implemented as written, were prepared to rely on what they considered to be the preponderance of the evidence.

<sup>79</sup> See N.J. WIKELY, *COMPENSATION FOR INDUSTRIAL DISEASE* 60-65 (1993).

eligibility criteria).<sup>80</sup> The Council found, first of all, that “where asbestosis is present when lung cancer is diagnosed, the lung cancer can be attributed with reasonable certainty to previous asbestos exposure.”<sup>81</sup> Turning to the harder problem, it concluded that a “substantial exposure” to asbestos doubled the risk of lung cancer *even in the absence of clinical evidence of asbestosis*.<sup>82</sup> Thus, the Council had to devise a practical way of determining whether exposure was sufficiently “substantial” to allow for compensation. One option would be to require claimants to quantify their exposure, but the Council recognized that that would not be workable in a scheme not “based on an individual proof system.”<sup>83</sup> It also rejected the continued use of diffuse pleural thickening as a criterion for a lung cancer award because it thought diffuse pleural thickening was an “unreliable” indicator of asbestos exposure.<sup>84</sup> The Council solved its problem by selecting a limited number of jobs that typically involved exposures to asbestos in amounts sufficient to double the risk of lung cancer.<sup>85</sup> The Council’s recommendations were

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<sup>80</sup> DEPARTMENT FOR WORK & PENSIONS, ASBESTOS RELATED DISEASES: REPORT OF INDUSTRIAL DISEASES ADVISORY COUNCIL 16-19 (July 2005). The Government endorsed these proposed changes, see Department for Work & Pensions, Press Release—Changes to the Schedule of Prescribed Diseases—Asbestos Related Diseases (July 14, 2007), available at <http://dwp.gov.uk/mediacentre/pressreleases/2005/ju/cdis014.asp> (last checked May 31, 2007). The Advisory Council’s recommendations were implemented in April 2006. See SI 2006/638, The Pneumoconiosis, Byssinosis, and Miscellaneous Diseases Benefit (Amendment) Scheme 2006, at 2. The current list of prescribed diseases is found at Department for Work & Pension, Guide to Industrial Injuries Disablement Benefits, Appendix 1: List of Diseases Covered by the Industrial Injuries Disablement Benefit at D8A, available at <http://www.dwp.gov.uk/advisers/db1/appendix/appendix1.asp> (last checked May 31, 2007).

<sup>81</sup> *Id.* at 17.

<sup>82</sup> *Id.* (emphasis added).

<sup>83</sup> *Id.*.

<sup>84</sup> *Id.*

<sup>85</sup> The eligible jobs were asbestos textile workers, asbestos sprayers, asbestos insulation workers including those applying and removing asbestos containing-material in shipbuilding. For exposures occurring before 1975, workers must be in the listed occupation for 5 years; for exposure after that

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incorporated into the schedule of prescribed diseases in April 2006.

The British experience highlights the conceptual difficulty in solving the lung cancer problem, even where it is not heavily politicized. Congress had the same challenge, but less leeway. The essential difficulty is to develop a satisfactory way to measure exposure. There were a number of options. First, Congress might have committed determinations of causation to the discretion of Physicians Panels. This option, however, would have made the operation of the lung cancer criteria completely unpredictable and would have had no support from any quarter. Second, Congress might have required more extensive pleural changes to qualify for a lung cancer award. This expedient would have preserved the basic structure of the act but moved the threshold for recovery a bit more in the defendants' direction. Because the connection between pleural changes and lung cancer is somewhat arbitrary (as the Industrial Injury Advisory Council found), this would not have responded effectively to fears that lung cancers would destabilize the finances of the program. Third, it could have adopted a quantitative threshold for measuring cumulative past exposures. That, however, would have had large transaction costs, and since it would often be impossible to prove exposure with any certainty, the program would have been under heavy pressure to adopt presumptions or other expedients to ease the burden of proof. And, finally, it could have followed the example of the British Industrial Injuries Advisory Council in adopting a more restricted list of the occupations and industries where employment would give rise to an inference of occupational exposure.

These options could have been used singly or in combination. All would have presented policy problems, which would quickly have become political problems. There simply was no good solution to the lung cancer issue. The stakes were too high; the outcome of the settlement model was too uncertain when transferred to the administrative context; and the medical

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time, 10-years' employment in the listed job would be required. *Id.* at 19.

disagreements were too deep. This issue was just too important to be left to the doctors—and in fact no one ever suggested referring the definition of the lung cancer medical criteria to the IOM, which was Congress's main vehicle for resolving other, less critical scientific issues on the merits. Nor could the IOM have executed that task without direction based on political judgments which related to the very issues that made the problem intractable to begin with.

#### 4. *The CT Scan Issue*

In the discussion to this point, I have repeatedly referred to the CT scan problem. This is a particular example of a more general phenomenon. Technological change will inevitably lead to more sensitive diagnostic techniques. In a medical model, that is clearly desirable. If legislation is intended to compensate people with a certain diagnosis, then better diagnostic techniques necessarily constitute improvements in the program. What's not to like?

For several reasons the picture changes under a settlement model. First, settlements are not judged on the basis of rigor and consistency, but practical results. The practical result of eligibility criteria depends on the diagnostic methods and technology in place when the settlement is negotiated. If the parties had contemplated a change in technology, they might well have agreed on different terms, which might have included stricter eligibility criteria. If this happens, improvements in diagnostic techniques do not make the settlement better but undermine its foundations.

This subversive effect is especially important when the condition being diagnosed is not the disease that is being compensated. This factor makes technological change especially important in Level VI—Other Cancer and Level VII—Cancer without Asbestosis.<sup>86</sup> In those categories, the disease being

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<sup>86</sup> While the defect of using pleural changes as a confirmation of exposure is especially apparent in lung and other cancer cases, the same problem also appears in the non-malignant categories. It is practically

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compensated is cancer. No one contends the pleural plaques in themselves cause, or are a risk factor for, lung or other cancer. The presence or absence of pleural plaques is a measurable surrogate, or stand in, for a factor that is thought (at least by some) to be causally related to these cancers – exposure to asbestos. Moreover, the reason that settling parties have traditionally looked at pleural plaques as a confirmation of substantial exposure is not that there is a close relationship between plaques and exposure, but rather there is a general relationship and the parties understand what it means in terms of the likelihood that claimants will be compensated. There is an element of arbitrariness in using a sign in this way, but it is the kind of arbitrariness that generally happens when parties engage in settling controversies rather than resolving medical questions. Rules of thumb of this kind are chosen because the line that is drawn has understandable practical consequences: defendants know how much they can expect to pay (given the prevalence of plaques in the cases submitted to them) and plaintiffs' counsel are willing to accept the rule of thumb as a fair resolution given what can be expected at trial. If, as a result of technological advances, pleural changes came to be diagnosed more widely (and presumably in cases of lesser exposure), the diagnosis would be less useful in establishing a sufficient level of exposure to cause cancer. In effect, it would be necessary to recalibrate the settlement model. In the tort system, this problem would be worked out over time in bargaining among the players, but in a legislated compensation scheme, there is no such self-correcting mechanism.

*C. Exposure*

All of the medical categories depend on proof of underlying exposure, but no one really knows exactly how much exposure

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impossible for pleural plaques by themselves to cause significant breathing impairment. However, pleural changes could be an indication of asbestosis that isn't showing up on a chest x-ray, and that asbestosis might cause impairment. Here again pleural changes are a partly arbitrary stand-in for the real causative factor.



any individual has. Unlike some radiation workers, who wear badges that purport to measure their cumulative dose of radiation, people exposed to asbestos did not have real-time monitoring. Indeed, prior to the 1970s, effective monitoring of asbestos concentrations in the work environment was uncommon; and even if those concentrations were known, precise information on where a person worked will be absent.<sup>87</sup> In litigation, the parties sometimes hire dose reconstruction experts to try to model the asbestos exposures to which a worker was subject. Obviously, however, an administrative compensation scheme would break down if dose had to be reconstructed by experts in this way.<sup>88</sup>

Thus, the FAIR Act's exposure standards were not based on measured doses, but rather on inferences from information on the industries where the claimant worked and the jobs he held. It was critically important that information on employment history be complete and detailed—if conclusory assertions regarding employment were acceptable, the exposure criteria would cease to be meaningful and the medical criteria for all of the disease categories in the bill (other than mesothelioma) would be undermined. S. 852 as reported was probably deficient in this regard, although S. 3274 made some significant

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<sup>87</sup> There were no national regulations regarding exposure to asbestos until OSHA adopted such regulations in 1971. Those regulation went through a number of iterations, but very early on, in June 1972, OSHA required workplace exposure monitoring. Because of this regulatory mandate, exposure monitoring became widespread during the 1970s. On the history of OSHA regulation of asbestos, see John F. Martonik et al., *The History of OSHA's Asbestos Rulemakings and Some Distinctive Approaches that They Introduced for Regulationg Occupational Exposure to Toxic Substances*, 62 AIHAJ 208 & 211 Table II (2001).

<sup>88</sup> Under the Energy Workers' Compensation Program, reconstruction of claimants' radiation dose is a major source of delay. General Accountability Office, *Energy Employees Compensation: Many Claims Have Been Processed, but Action Is Needed to Expedite Processing of claims Requiring Radiation Exposure Estimates*, GAO-04-958, at 17-21 (Sept. 10, 2004). That is true, moreover, even though radiation workers subject to that program wore badges that kept track of their exposure. Just reading the badges has proved to be a time consuming procedure.

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improvements.<sup>89</sup>

The second major exposure problem arises from the FAIR Act's focus on occupational exposure to asbestos. This is perhaps an inevitable result of thinking in terms of the settlement model. In the tort system, lawsuits based on non-occupational exposure are very rare, and settlements typically do not address such situations.<sup>90</sup> Moreover, the drafters assumed that all of the diseases compensated under the FAIR Act, other than mesothelioma, would require an amount of exposure that could not in practice be satisfied except in an occupational setting.

What works, however, in the rough and ready world of tort settlements does not necessarily work in a legislative scheme. Non-occupational exposure was politically important for three reasons.

First, at least some of the people exposed to asbestos from the W.R. Grace vermiculite mine in Libby, Montana, were exposed non-occupationally. The Libby situation was a *cause celebre* which produced a prize-winning series of articles by Andrew Schneider in the *Seattle Intelligencer*, a follow-on book, and some gripping television in which Mr. Schneider incredibly claimed that the main purpose of the FAIR Act was to address the Libby experience.<sup>91</sup> While Libby might have been peripheral

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<sup>89</sup> Section § 121 (c) (2) in S. 3274, while continuing to allow claimants to prove exposure by affidavit, would have required such affidavits to be "detailed and specific." *Id.* This combined with detailed submission requirements relating to employment and exposure would provide the Administrator with a sufficient record to evaluate allegations of exposure, and § 121 (c) (2) (C) allows him to require additional information if necessary. None of this is perfect. Employment records typically show no more than the fact of employment and (sometimes) occupation, and coworker testimony in the asbestos context is not very reliable. The program would inevitably depend on the claimant's sworn testimony to some extent, and the hope of the bill's supporters was that the penalties for fraud combined with the need to provide specific statements that could in principle be verified will keep false statements down to a manageable level. Exactly the same problem bedevils in the tort system, of course.

<sup>90</sup> Take-home exposure is classified for this purpose, as it is under the FAIR Act, as occupational exposure.

<sup>91</sup> Libby, Montana is the site of a former W.R. Grace vermiculite mine

to the asbestos litigation issue in general, it was not peripheral to Montana's senators, and Senator Max Baucus (D-MT) was one of the main sponsors of the bill and a key to obtaining support from Democrats.

Second, during the bill's consideration the press in California gave considerable play to the possibility that exposure to naturally occurring asbestos there and in other states might cause disease.<sup>92</sup> This was obviously of great concern to California Senator Dianne Feinstein, another key supporter of the bill on the Democrats' side.<sup>93</sup>

Third, the destruction of the World Trade Center on September 11, 2001, and the destruction of many buildings on the Gulf Coast by Hurricanes Katrina and Rita released asbestos from buildings that, it was feared, might someday cause disease.<sup>94</sup>

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and processing center. The vermiculite produced at Libby contained tremolite asbestos. Most people who were exposed to tremolite at Libby were exposed on the job, but some were exposed in the community. Libby residents assert that pleural conditions resulting from their exposure to tremolite are more likely to be impairing than exposures to other forms of asbestos. The Libby "story" was broken in a series of articles in the Seattle Post-Intelligencer in the late 1990s. The authors of those articles subsequently developed and updated their views in A. SCHNEIDER & D. MCCUMBER, AN AIR THAT KILLS (2004). For more details on Libby and the provisions of the FAIR Act relating to Libby, see *Elegy*, *supra* note 30, at 525-26.

<sup>92</sup> See, e.g., C. Dahlberg, "Tracing asbestos victims is tough; It's hard to establish levels of health risk posed by naturally occurring minerals in developing areas, SACRAMENTO BEE, July 10, 2005, Metro A1, at 1.

<sup>93</sup> At Senator Feinstein's request, the bill was amended in mark-up (through a managers' amendment) to add § 502, which contained extensive regulatory provisions relating to naturally occurring asbestos, as well as § 121 (g) (10) (allowing people exposed to naturally occurring asbestos to file an exceptional medical claim). See S. Rep. 109-97 (2005) at 45, 79.

<sup>94</sup> As a result of concerns about asbestos at the World Trade Center site and in New Orleans, Senator Hillary Clinton (D-NY) and Mary Landrieu (D-LA) proposed amendments, which were accepted by Senator Specter and Senator Leahy, that would give people who claimed to be injured by asbestos from those two disasters the right to file an "exceptional medical claim." S. 3274, § 121 (g) (11). See also Senate Asbestos Bill Expands to Include Hurricane, 9/11 Victims, <http://safety.com/articles/senate-asbestos->

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The Senate did not feel comfortable excluding even the possibility of an award for diseases other than mesothelioma in any of these settings, just because exposure was not occupational.<sup>95</sup> The solution adopted by the Senate Judiciary Committee in all of these cases was to underscore the authority of Physicians Panels to adjudicate causation through the exceptional medical claims procedure.

The three situations on which the Senate focused, however, are just special instances of the general problem of community exposure. The FAIR Act arguably should have been read in any event to allow claimants to present a case on causation to Physicians Panels in any non-occupational exposure case. The bill did not, however, provide the panels any clear guidance on how such cases should be decided (except in the case of Libby exposures, where the bill clearly departed from any sensible method for ascertaining causation in order to provide a special benefit to that community). The settlement model basically failed to provide any guidance for non-occupational exposures, because there were very few settlements involving that situation. The medical model was of little assistance because the medical issues surrounding these kinds of exposure were contested and because

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bill-expands-to-include-hurricane-9/11-victims.html. For the World Trade Center, see, e.g., Sewall Chan, *Hard To Tell What Causes Fatal Disease to Lungs*, NY Times, Feb. 13, 2007; Anthony DaPalma, *Illness Persisting in 9/11 Workers, Big Study Finds*, NY Times, September 6, 2006 (Health Section). For New Orleans, see Sewall Chan & Matthew Wald, *Storm & Crisis: Overview, Officials Prepare for Partial Return of Residents*, NY Times, September 17, 2005 (News).

<sup>95</sup> S. 852 contained a number of highly controversial special provisions for people exposed to asbestos in Libby, Montana. See *Elegy*, *supra* note 30, at 526. A key provision was to allow people who ever resided in or near Libby to qualify for benefits to be determined by a Physicians Panel without regard to occupational exposure. S. 852 § 121 (g) (8). The same approach was subsequently applied to naturally occurring asbestos. S. 3274, § 121 (g) (10). Several amendments pending on the floor when the bill failed (Nos. 2834 (Landrieu); 2877 (Clinton)) proposed relaxing the occupational exposure requirement further in the case of the World Trade Center attack and natural disasters such as Hurricane Katrina. The substance of those amendments eventually found their way into S. 3274. See S. 3274, § 121 (g) (11).

Congress had no interest in cutting off claims in circumstances that attracted a great deal of public attention if there existed even a possibility that some claims would be valid. The obvious thing to do was to punt the issue to the Physicians Panels. Environmental exposure to asbestos is ubiquitous, however, and leaving the question of causation to individual determination by the Physicians Panels without providing any direction on how causation was to be determined created an important uncertainty about the operation of the act.

#### CONCLUSION

In the months leading up to the original introduction of the FAIR Act in 2003, the asbestos litigation system had so deteriorated from the defense point of view that there was an unusual propensity to take a chance on a new system. This was especially true for defendants, because financial markets were largely closing for any company thought to have an “asbestos problem.” By that time asbestos litigation had come to involve around 8,400 companies, and many were afraid that their potential asbestos liabilities might become economically life-threatening.<sup>96</sup> But even insurers, who were somewhat less vulnerable, considered asbestos litigation to be out of control and were more willing than they had been previously to contemplate a legislative option.

As time passed, however, this appetite for risk declined. From the defense perspective, the tort system was significantly improving every year. Many courts either formally or informally deferred the cases of the unimpaired, and several states enacted medical criteria bills. The interstate forum shopping that had driven the post-*Amchem* explosion of asbestos claims abated. Large scale consolidations stopped. And as a result of these and other factors, including the increasing scandal that began to be associated with asbestos litigation, filings plummeted. The Manville Trust, for example, which received 93,764 domestic cases in 2003, received only 16,607 in 2005—and most of that

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<sup>96</sup> RAND REPORT, *supra* note 5, at 6.

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decrease was in the non-malignant category.<sup>97</sup> Defendants in the tort system saw a similar, if less drastic, reduction in filings.<sup>98</sup> More and more companies were sanguine enough about the tort system that they no longer felt compelled to endorse a radical (and inherently unpredictable) change. At the same time, the political process was steadily pushing up the cost of the program. The viability of the FAIR Act depended increasingly on how many claims, of what kind, would be filed under the new system. And the answer to this question depended in large part on the adequacy of the bill's medical eligibility criteria.

Critical aspects of the medical criteria were surprisingly uncontroversial. For example, the criteria separating Level I (the unimpaired) from impaired claimants was little discussed, although that line has been highly controversial in state medical criteria legislation. Similarly, there was not much debate about the criteria for non-malignant Levels III through V, which covered steadily more impairing cases of asbestos related disease. Nor was there any real controversy over the medical criteria for mesothelioma. This general area of agreement, however, left ample room for dissension.

Facing intractable medical issues, the sponsors of the bill used three primary strategies. First, they referred some medical issues to the IOM, which was a trusted, independent source of medical expertise. The most important issue of this kind was a determination of general asbestos causation for cancers other than lung cancer and mesothelioma. More political medical issues were, however, too "hot" to be referred to the experts and were addressed in other ways.

Where a neutral medical determination was unattainable, the Senate looked toward settlements in the private sector (including bankruptcy trusts) as a model for developing standards of its own. The settlement model was widely useful and resulted in many of the areas of broad agreement. But, it did not provide an adequate answer to the problem of lung cancer claims where there is no underlying asbestosis. The problem was that there

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<sup>97</sup> Hanlon & Smetak, *supra* note 1, at 594.

<sup>98</sup> *Id.*.

was an insufficient level of confidence that the FAIR Act's administrative system would behave like the tort system—applying criteria that worked in an adversarial system with high transaction costs could have unexpected consequences in a non-adversarial system with low transaction costs.

The settlement model similarly failed (but for different reasons) in dealing with problems such as non-occupational exposure that were very important politically, but had not been important in the asbestos litigation. Here the Senate avoided resolving the issues by delegating them to a Physician's Panel, but that was probably not a stable solution and would not have been accepted in the (then-Republican) House of Representatives. The problem was that the financial consequences of decisions by Physicians Panels in cases of non-occupational exposures where there essentially were no exposure criteria were too large to tolerate.

It is hard to know whether the level of risk perceived by the defense community in 2006 would have caused it to blanch in 2003. When the FAIR Act was first introduced, the tort system was in such desperate shape that most defendants were prepared to take some chances on an untried system. But as the tort system improved (partly as a result of the pendency of the bill itself, which reduced the incentive of plaintiffs' lawyers to recruit new cases), the burden of proof to be carried by the new system steadily grew. One major reason for the failure of the bill in 2006 was that the various ways adopted by the Senate to resolve medical issues in an environment of extreme distrust on scientific issues could not in the end sustain this growing burden. Division in the business community, and a reduced level of commitment even among businesses that supported the bill, eventually created the political space in which the conservative opponents, who disliked the bill for both political and ideological reasons, could operate. In the end, these conservatives, adding their voices to the opposition from that part of the Senate that responded to the interests of trial lawyers and their allies, brought on in the St. Valentine's Day Massacre of the FAIR Act.